MINUTES
HSC ACTUARIAL ADVISORY COMMITTEE
February 18, 2004

Members Present: Kevin Campbell; Tom Coogan; Kevin Earls; Scott Gallant; Tom Holt; Rick Jones; Rich Monnie; William Murray; Sarah Reeder.

***Members Absent*:** Barney Speight

Staff Present: Darren Coffman; Alison Little, MD, MPH; Bruce Goldberg, MD; Laura Lanssens.

Also Attending: Stephanie Davis, Will Eichman, and Ed Fischer, Mercer Government Human Services Consulting; Mike Wiltfong, Oregon Health Policy and Research (OHPR); Wee Yuen Chin and Jeff Peterson, Willamette Dental; Colleen Guido and John Hofer, Dept. of Consumer and Business Services (DCBS); David Cole, Lane Individual Practice Association (LIPA); Jo Bell, Oregon Association for Hospital and Health Systems (OAHHS); Marylou Hazelwood, Office for Medical Assistance Programs (OMAP); Ann Uhler; Government Council on Alcohol and Drugs; Maureen King, Dept of Human Services (DHS); Jane Myers, Oregon Dental Association (ODA); Bennett Kong and Marc Berg, Providence Health System; John Britton, Legislative Fiscal Office.

I. Call to Order

The first meeting of the HSC Actuarial Advisory Committee was called to order at 2:30 pm in Basement Conference Room A of the Public Service Building, 255 Capitol Street NE, Salem, OR. Members of the Committee and staff introduced themselves around the table.

II. Overview of HB 3624

Dr. Bruce Goldberg, OHPR Administrator, gave an overview of HB 3624 and the purpose of this Committee. He felt that the legislation reflected the consensus that health care providers are getting paid too little to serve Oregon Health Plan (OHP) clients. He sees the goal of this process to define a set of benchmark mark rates that can reflect the ideal of reimbursing at cost. While the legislature will never be able to allocate enough money to the OHP to satisfy everyone, these benchmark rates will serve as a tool in order to better inform the decisions of which eligibles to cover, what benefits to provide, and at what reimbursement levels, based on the available resources.

Dr. Goldberg indicated that the Health Services Commission (HSC) is charged to develop a set of both benchmark fee-for-service (FFS) and managed care rates. A RFP

process resulted in a contract with Mercer, a firm with strong expertise in rate setting in general and Medicaid managed care capitation rate setting in particular. This Committee has been convened to provide a resource for regular stakeholder input into the process. He hopes that the result will in a reasonable and fair product representing an equitable valuation of services.

III. Goal of Meeting/Timelines

Darren Coffman reiterated that the goal of this meeting is to provide input to the HSC through an open process. Today's meeting will allow the Committee to identify potential sources for cost measurement. The second meeting scheduled for March 17th will allow feedback on the draft methodology developed from that input prior to the HSC's consideration of it on the following day. A third meeting will likely be needed in May once Mercer has had a chance to start working with the data. A fourth meeting will be held in July once the draft report on the benchmark rates is available to comment on. Mr. Coffman saw the committee as having an ongoing value as the legislation calls for the HSC to develop new benchmark rates for each successive biennia.

IV. OHP Actuary Benchmarking Services - Mercer Government Human Services Consulting

Stephanie Davis of Mercer Government Human Services Consulting introduced herself as the Project Manager for the team and also introduced the other members of the Mercer team accompanying her: Ed Fischer, Assistant Project Manager and Will Eichman, FSA, CPA, Lead Actuary. Ms. Davis said that more members of the team would be working behind the scenes, with each having a particular area of expertise (e.g. pharmacy, dental).

Will Eichman reviewed an outline of the benchmarking process with the Committee. In general, rates can only be as good as the data going into them. FFS and encounter data for fiscal year 2001 and 2002 will be acquired from OMAP. He understands that the managed care plans have sign-off authority for the encounter data and, while no data source is perfect, this is the best source to use as a starting point. Other data sources could include Oregon-specific provider cost data, other States' data, and managed care organization financial data. Typical actuarial adjustments will then be applied to the data to trend forward to the benchmarking period (FY 2005 and 2006), insure internal consistency of the data, and reflect any program changes, and finally, adjustments made to reflect total costs. This last adjustment is key to the process in converting what is paid (or more accurately, appropriated) to cost.

Mr. Eichman indicated that they are suggesting that the basic eligibility categories that the stakeholders are familiar with be used (e.g. Children age 1-5, Old Age Assistance (OAA) with Medicare, and possibly the OHP Standard populations). OMAP has more

detailed categories available but these will likely be sufficient unless significant variation is seen within these populations. It was also noted that maternity delivery cases would be reported separately. Benchmark rates would be developed for each of these eligibility groups.

Mr. Eichman indicated that HB 3624 asks that geographic variation be examined as part of the benchmark rate setting process, but does not specify that separate rates for different regions of the State need to be reported. At the FCHP's Rates & Actuarial Workgroup meeting that the Mercer team presented to in the morning they did not hear about any major concerns with the regions as they were currently defined so they would suggest using these same definitions when examining the regional variance. However, it was noted that the definitions for the five regions currently in place has not been reviewed in over ten years and a re-examination may be in order. At this time it is suggested that only statewide benchmark rates be established. While some HSC members had suggested regional consideration be given, Kevin Campbell and Jo Bell both advocated for statewide rates only.

Mr. Eichman then listed the six service categories for which benchmark rates need to be established according to the legislation: hospital, physician, prescription drugs, durable medical equipment (DME)/supplies, and other services. It was already decided that mental health would need to be separated out and just this morning they heard from the FCHPs that chemical dependency should also be broken out.

At this point, discussion was opened up on the appropriateness of various potential cost measures for the service categories. Some data sources already identified by Mercer include Oregon Medicaid data (FFS & encounter data, FCHP financial data), Medicare data (hospital cost reports, hospital cost settlement reports, DRG reimbursement rates, allowable charges, and the resource-based relative value scale (RBRVS), Mercer databases (pharmacy/provider costs of other states), and other databases (AWP pricing information, reasonable and customary cost data).

Scott Gallant expressed concerns that any comparisons with other states' data be on an "apples to apples" basis as hospital utilization and physician practice patterns are different here than in other states. Allowances can also be made for Oregon's use of the Prioritized List, although the list wouldn't be applied to the data directly. It was recognized that Washington would be an optimal state for comparison purposes, but Mercer does not have access to their claims level data.

Mr. Eichman indicated that the measures being sought should represent the average cost of the services, representing nobody in particular but everyone in total. The cost should include the direct cost of medical care plus some overhead. Once the average cost is determined, Mercer will then make adjustments for the Medicaid population being studied. Dr. Goldberg added that the goal is to reflect a reasonable cost, using a measure that can be calculated and verified in some manner. Another way of looking at it is what data is leading you to conclude that the OHP is not covering costs.

Mr. Gallant indicated that the AMA has issues with certain portions of the RBRVS formula. Oregon-specific adjustments and Medicare cuts in recent years need to be recognized. He can put the Mercer team in contact with technical experts to explain the issues in detail. He also pointed out that there can be significant differences between what is appropriated by the state to go towards providing certain services through capitation payments, and what is actually paid to providers. The FFS rate in Oregon has been $25.95 for five years, with an adjustment added for obstetrics. He added that reported physician behavior is evidence that reimbursement rates are below cost.

Tom Coogan noted that the federal government is cutting DME services and that there is a freeze on the Consumer Price Index (CPI). Marc Berg offered that the financial statements of publicly traded DME providers could be as a measure of cost.

Tom Holt asked whether the goal is to find the product cost or the cost of providing the service? If the latter, in addition to product costs, there are Medicaid specific dispensing fees, and an increasing demand for charity care. He saw the Maximum Allowable Cost (MAC) pricing as being much more critical than the Average Wholesale Price (AWP) included in the First Data Bank database. He asked that Mercer be sure to capture increases in labor costs and health care inflation in developing pharmacy costs. Ms. Davis indicated that there is a national survey that can be used to compare, for example, caseworker wages in Portland vs. the national average. She also pointed out that the fastest growing component of health care is currently administration, due mostly to the implementation of HIPAA.

Rick Jones was happy to hear that others were advocating that chemical dependency be evaluated separately. He said that costs for these programs vary greatly depending on the program. For instance, his is the only other program other than Kaiser that is owned by a health plan. He also pointed out that chemical dependency results in offsets resulting in, for example, reduced emergency department utilization.

Sarah Reeder said that 90% of home-health agencies are hospital-based. Federal regulations have changed the payment system from a per diem, to an interim payment system, and now to a prospective basis. Also worth noting is that non-hospital based home health agencies use a fiscal intermediary to facilitate payment to providers. Marc Berg indicated that their cost reports could be acquired from the FI since they aren't filed with the state. Mr. Berg said it was his general impression that pharmacy and DME are reimbursed at high rates, hospitals are reimbursed at moderate rates, and home health care is reimbursed at low rates.

Many Committee members pointed out the vast number of program changes that took place during the historical period from which utilization data is being pulled. There were also concerns about the effect of both federal and state laws that have either recently gone into effect or will shortly. For example, Kevin Campbell noted the new Oregon mandate that at least 75% of mental health services follow evidence-based practices by 2009. Dr. Goldberg cautioned that this process is not meant to make either the past or the present perfect. Both he and Kevin Earls saw the benefit of the benchmark rates

more in directing the allocation of additional OHP funding by the legislature in an equitable fashion.

Ms. Davis said that to the extent that the measures can be tied to a national standard, the better. In this way, the measures would not have to be revisited in a detailed manner every two years.

Mr. Coffman asked the members to provide him with their input on the best measures of reasonable costs and, if possible, either access to that information or directions on how to gain access to it. If the data is of a sensitive nature, Mercer will be happy to sign a confidentiality agreement. Mercer will then come back to the March meeting so the Committee can look at the approach developed from that input.

A sample sheet (with fictitious numbers) was handed out to show the proposed layout of the benchmark rate calculations (See Attachment 1). The groups of columns represent (1) historical reimbursement rates for FY 01-02), (2) adjustments to reimbursement rates including trend and program changes, (3) projecting FFS reimbursement forward to the prospective time period (FY 05-06), (4) FFS benchmark rates (cost), and (5) managed care benchmark rates (cost). It was pointed out that column 4a, representing the adjustments to go from FFS reimbursement to FFS cost will be the focal point of the discussions of this Committee. Documentation will then show whether disproportionate share hospital (DSH) and graduate medical education (GME) payments are included so that others can calculate hospital specific rates from the benchmark.

It was suggested that it would be helpful if a separate column could be included to show what percentage of the benchmark the State paid at. It was pointed out that PwC would be calculating capitation rates through a separate process, and their numbers would not be available when the Benchmark Rate Report would be published.

V. Adjournment

The meeting of the HSC Actuarial Advisory Committee was adjourned at 4:54 pm. The next meeting will be held March 17, 2004, 2:30 pm – 5:00 pm, in Conference Rooms 102 & 103 of the Oregon State Library, 250 Winter Street NE, Salem, OR. A subsequent meeting was scheduled for Wednesday, May 26th from 11:00 am - 1:00 pm at a location to be determined.

Attachment 1:

Committee Members:

Kevin Campbell	Greater Oregon Behavioral Health Inc (GOBHI)
Tom Coogan	Care Medical
Kevin Earls	Oregon Assn of Hospital and Health Systems (OAHHS)
Scott Gallant	Oregon Medical Association (OMA)
Tom Holt	Oregon State Pharmacy Association (OSPA)
Rick Jones	Choices Counseling Center
Rich Monnie	Capitol & Managed Dental Care
William Murray	Doctors of Oregon Coast South (DOCS)
Sarah Reeder	Oregon Association for Home Care (OAHC)
Barney Speight	Kaiser Permanente NW Region
Yuen Chin (alternate)	Willamette Dental
Jim Russell (alternate)	Mid-Valley Behavioral Care Network (MVBCN)

Attachment 2:

A. Stephanie Davis introduced the Mercer team.

B. Reviewed with the Committee the benchmarking process.

1. Requirements of benchmark study
2. Methodology: General Data
3. Methodology: Report Structure – Preliminary
   - ✓ Eligibility Categories
   - ✓ Geographic Regions
   - ✓ Categories of Service
     - Hospital
       - Inpatient
       - Outpatient
       - Emergency Room
     - Physician
     - Prescription Drugs
     - Mental Health
     - Other Services
       - Chemical Dependency
       - Home Health Care
       - Other services provided within managed care
       - Other services provided on a fee-for-service basis
       - Transportation?
       - Vision?
4. Methodology: Data Sources
   - Oregon Medicaid Data
   - Medicare Data
   - Mercer Databases
   - Other Databases

MINUTES
HSC Actuarial Advisory Committee
March 17, 2004

Members Present: William Murray; Rich Monnie; Sarah Reeder; Tom Holt; Kevin Earls; Tom Coogan; Kevin Campbell; Scott Gallant; Joel Daven, MD; Rick Jones (attempted teleconferencing).

Members Absent: Barney Speight.

Staff Present: Darren Coffman; Alison Little, MD; Bruce Goldberg, MD; Laura Lanssens.

Also Attending: Stephanie Davis and Will Eichman, Mercer Government Human Services Consulting; Mary Lou Hazelwood and Linda Moss, Office of Medical Assistance Programs (OMAP); Maureen King, Department of Human Services (DHS); Ann Uhler, Mental Health Care & Chemical Dependency Subcommittee; Jane Myers, Oregon Dental Association (ODA); Marc Berg, Providence Health System; Bill Guest, Cascade Comprehensive Care, Inc.; Jeff Peterson, Willamette Dental; John Britton, Legislative Fiscal Office.

I. Call to Order

Dr. Bruce Goldberg, Administrator for the Office of Oregon Health Policy and Research called the HSC Actuarial Advisory Committee to order in conference rooms 102 & 103 of the Oregon State Library, 250 Winter Street NE, Salem, OR. Introductions were made all around.

II. Goal of Meeting

Dr. Bruce Goldberg reiterated the purpose of the Committee is to provide the Health Services Commission (HSC) and Mercer team with a forum for getting input and feedback from stakeholders representing the major health care sectors. He explained that today, Mercer would be presenting their latest thoughts on how best to establish the benchmark rates called for in HB 3624 to account for the cost of health care. After considering the input received from this committee since the last meeting, they will give their current recommendations on the approach to take and welcome the Committee's feedback.

Dr. Goldberg wanted to make it clear that the benchmark will not determine what will be paid under OHP, but rather establish a "stake in the sand" as to what a reasonable estimation of cost might be. A desired outcome of the process is that the benchmarks can be used by the legislature to establish consistency in reimbursement levels across health care sectors. He knows that this is a complex task and it may be more difficult in some areas than others, but is optimistic that an easily understood methodology that

instills confidence from stakeholders in working towards a goal of equity can be achieved.

III. Report on Cost Measure Input Received

Darren Coffman briefly thanked the Committee members for their input on potential data sources for measuring cost within each of their sectors. After he collected all of the information provided to him he then forwarded it on to the Mercer team. He indicated that the Mercer team will be commenting on each of the additional data sources suggested and if and how they would recommend using that information as part of the benchmarking process.

IV. Draft Methodology for OHP Benchmark Rates - Mercer Government Human Services Consulting

Stephanie Davis of Mercer Government Human Services Consulting recapped the discussion held at the last meeting. She said that they are still in the early stages of their work and nothing is final in relation to the recommendations being made at this point. They still have yet to see what the data looks like and won't see the OHP data until early May, although some commercial data might be available within the next couple of weeks. In addition to a review of the data sources they've considered and are recommending at this point, they plan to talk about how the calculation of trend rates will be done.

A. Benchmark report structure

Ms. Davis said that the recommended eligibility categories have not changed since the January presentation. Kevin Campbell suggested, and there was agreement, that the OHP Standard categories for OHP Families and OHP Adults/Couples should be kept in the report, as we may be able to add these populations back in the future.

Also, Mercer heard clearly from this Committee that regional variation should not be factored into the benchmarking process, so Mercer is recommending that only statewide benchmark rates be developed.

Will Eichman noted that they have added chemical dependency to the list of service categories for which separate fee-for-service (FFS) and managed care benchmark rates will be established, based on the Committee's input at the last meeting. And while 'Other Services' will be presented as a single category in the report, he assured the Committee that specific services such as home health, transportation, and vision will still be analyzed in detail.

B. General benchmarking approach being recommended

Scott Gallant suggest that the report should show a comparison of the ideal reimbursement represented by the benchmark rates against not only what the proposed OHP rates are for 2005-07, but also what was historically paid in 2001-03 and 2003-05.

Mr. Eichman said that the benchmark rates would build from the historical data from the 2001-03 biennium and trend forward to the 2005-07 benchmarking period. He said that the cost adjustment identified in the spreadsheet as part of the report will provide the basis for comparison between the benchmark rates and the PwC calculated capitation rates. He sees the key piece of the report as providing the legislature with a PMPM for each category of service that, when divided by the total amount across all categories, will represent the desired distribution of the "total pie". The legislature can then choose to reallocate money according to what would be most equitable. Dr. Goldberg added that anyone would be able to overlay the benchmark with what has been paid historically.

Kevin Earls summarized why he felt the legislature asked for this work to be done. When the legislature is forced to make cuts, effectively reducing the rate of pay for services, they want a method for doing this in an equitable fashion. And if additional money should become available, they want a way to be able to put it into the system equitably. In the past 4-5 years he has seen an increasing amount of money going towards prescription drugs. He believes we are hard pressed to reduce the amount in terms of a similar magnitude when forced to take money out of the plan. Tom Holt concurred and added that we are talking about costs associated with providers here. In the case of prescription drugs, the cost associated with the manufacture of the drug (a product) is a different issue from that associated with the pharmacist dispensing the drug.

Mr. Eichman explained that the benchmarking process that they are recommending at this point is to use, to the greatest extent possible, a uniform measuring tool. Because of the uniformity of the Medicare fee schedule, they will be recommending its use as the "measuring stick" where appropriate.

In general, the approach calls for a relative weighting of payments made by commercial plans, Medicare, and Medicaid. If, for example, commercial plans were to pay at twice the rate of Medicare and Medicaid paid half of Medicare, and a simplifying assumption that each payer represented 1/3 of the market, the benchmark would be 117% of Medicare.

Bruce Goldberg offered that the methodology assumes that the market is at equilibrium. That most providers are making their costs through the mix of reimbursement they get from commercial, Medicare, and Medicaid patients. The benchmark should ideally use the same "stick in the sand" as a comparator, but it can't be done for some categories such as dental services, where no Medicare fee schedule exists.

C. Recommendations for cost measures by service category

Will Eichman then began an explanation of the data sources considered for each health care sector, and which are being recommended for use in determining the benchmark rates, starting with physician services.

Physician Services

Mr. Eichman identified the addition data sources suggested through the Committee's input as being the MGMA (Medical Group Management Association) cost survey of physicians, the Washington and other states' Medicaid fee schedules, and commercial reimbursement rates in Oregon. The "measuring stick in the sand" being recommended for physician services by Mercer at this time is Medicare RBRVS (Resource-Based Relative Value Scale). A "watermark on the stick" would then be determined using the market equilibrium approach to establish the benchmark for cost. This would be done using a blend of the following data sources:

- Medicare RBRVS, geographically adjusted to Oregon
- Medicaid fee schedules in Oregon
- Commercial reimbursement rates for Oregon

The next step in the process will be to obtain the data and assess what percentages of physician services are done in the Medicare, Medicaid, and commercial settings. These percentages can be different for each service category and will be used to weight the total reimbursements calculated for each of these major payers. Data from other states and the other sources suggested can then be as a comparison to see if the results make sense.

Mr. Gallant asked whether such things as the medical inflation index, Medicare inflation, liability issues, and the lack of compensation for limited English proficiency would be taken into account. It was noted that inflation and malpractice insurance will be factored into the trend rate, but very specific details such as translation services can be analyzed as a part of this process.

Hospital Services

Mr. Eichman indicated that the additional suggested data sources for hospital services included the Medicare cost reports for Oregon hospitals, other States' Medicaid hospital costs, and commercial reimbursement rates in Oregon. The measurement tool recommended for use for hospital services is Medicare reimbursement, with the cost mark blending:

- Medicare cost reports in Oregon
- Medicaid fee schedules in Oregon
- Commercial reimbursement rates for Oregon

This would use the DRG fee schedule for inpatient services and ambulatory payment groups for outpatient services. The numbers would then be aggregated to arrive at a

single hospital benchmark rate. The same process would be used as with physician services to then asses the relative portion of costs related to each of the major payers, arrive at the "watermark" on the measuring stick and check that the results against other states.

Mr. Earls noted that the methodology would be a blending of high commercial payments and low Medicare and Medicaid rates, except in the case of prescription drugs, where the differences will be much less.

Prescription drugs

Mr. Eichman gave the additional data resources suggested by the Committee as the Oregon Secretary of State audit of institutional prescription drug costs, commercial reimbursement rates in Oregon, and other States' Medicaid prescription drug rates.

In the case of prescription drugs he said that the only real basis for measuring cost is AWP (Average Wholesale Price) + dispensing expenses. In this case, a different approach will need to be employed. He broke the equation into three different components or "silos": 1) drugs for which only brand names are available, 2) drugs which have generics from a limited number of manufacturers, and 3) generics available from many manufacturers. In the latter case, MAC (Maximum Allowable Cost) pricing reflects true competition taking place. In the first two instances, effective discounts will need to be estimated. These three amounts will then be blended to get overall discounted rate, upon which rebates will be assessed as a percentage. The cost mark will reflect a blending of the following based on drug utilization rates:

- the Mercer MAC list (with consideration of Oregon's MAC list) for a subset of generics and multi-source brands, converted to a percent of AWP, and
- a percent of AWP for non-MAC drugs (single source brands and the remainder of the generics and multi-source brands).

Then an amount will be added representing the Oregon Medicaid FFS dispensing fee. The results will be compared to other states and the Wholesale Average Cost (WAC).

In the essence of time, Dr. Goldberg asked that all discussion on cost measurement for individual categories of services be held until the presentation is completed.

Durable Medical Equipment (DME)

The additional data sources noted by Mr. Eichman for DME included financial statements from publicly traded DME providers, Washington and other states' Medicaid rates, and commercial reimbursement rates in Oregon. Mercer is suggesting the use of the Medicare allowable charges as the measuring tool for DME services. The cost mark would be a blend of:

- Medicare allowable charges, geographically adjusted to Oregon,
- Medicaid fee schedules in Oregon, and
- Commercial reimbursement rates for Oregon.

In this case there has been concern raised about recent adjustments to Medicare allowable charges and the fact that they won't be in line with historical reimbursement and input will be solicited from industry representatives on how to best address this issue.

Dental

In the case of dental, only commercial reimbursement rates in Oregon and other states' dental rates were suggested as additional data sources. Mr. Eichman noted that there is no Medicare payer for dental services so the measuring tool suggested is the Oregon Medicaid fee schedule. The benchmark watermark will then be a simply be a blend of:

- Medicaid fee schedules in Oregon, and
- Commercial reimbursement rates for Oregon.

This result will again be compared to other states for reasonableness.

Mental Health and Chemical Dependency (MHCD)

The additional data sources suggested and issues surrounding the reimbursements of these two service types are largely similar so were addressed at the same time. The additional sources suggested for both were Oregon hospitals' financial data, commercial reimbursement rates in Oregon, and Washington and other states' Medicaid MHCD rates. In the case of mental health, the Oregon Mental Health Organizations' (MHOs,) cost studies were also suggested. Here, the Medicaid fee schedule is also being suggested as the measuring tool. The primary reason is that the Medicare benefits in these areas are far more restricted than for Medicaid. The breadth of coverage for commercial products is also not as great. Those reimbursement rates will still be used to establish the benchmark rate, however, but will be weighted less in the blending of:

- Medicaid fee schedules in Oregon,
- Medicare cost reports and fee schedules, geographically adjusted in Oregon, and
- Commercial reimbursement rates for Oregon.

The MHO cost studies and hospital financial reports will be used to validate the cost measure with the data from other states used for comparison purposes.

Other Services

Mr. Eichman indicated that good information on the pluses and minuses of additional data sources was supplied, with those including *home health* cost reports for hospital-based and free-standing agencies, Oregon hospitals' financial data, commercial reimbursement rates in Oregon, and Washington and other states' Medicaid home health services rates. Home health follows the typical pattern, with Medicare reimbursement being the suggested measuring tool and arriving at a cost mark by blending commercial, Medicare, and Medicaid rates. The Home Health Cost Reports can then be used to validate that figure in addition to looking at other states' data.

Both *transportation and vision services* were reported to follow the same methodology. No additional data sources were identified, and Medicaid reimbursement is the recommended measurement tool. As these services are limited or non-existent in Medicare and commercial plans. A percentage of Oregon Medicaid fee schedules would be used to establish the cost mark, with comparisons to commercial rates made where possible (e.g. ambulance). Comparisons to other states Medicaid fee schedules will be even more important in these cases since other data sources are scarce.

D. Development of medical inflation (trend) factor

This topic was not discussed in this meeting. However it will be a topic of discussion at the next meeting on May 26, 2004.

E. Discussion by the Committee

Regarding home health, Marc Berg said that there is going to be a need to go out and get additional data in order to make the necessary calculations.

Ann Uhler thought that it would be hard to use commercial reimbursement for MHCD benchmarking. They cover a healthier population and these services are not being covered at parity levels, if at all. Mr. Gallant added that PEBB (Public Employee's Benefit Board) has one year's experience with mental health at parity. Also, he suggested looking at a study on mental health services that was paid for by the OMA (Oregon Medical Association).

Kevin Campbell concurred on the issue related to parity and thought that the issue could be dampened to some degree by looking at it on a cost per unit basis. He also mentioned that the MHOs were submitting cost data along with their encounter data.

Jane Myers presented written testimony from the Oregon Dental Association. She said that in order to determine cost of service without profit, you would have to go to the providers for that information. She believes that some profit will need to be included in the payment in order to encourage long-term participation. Also she wanted to point out that FFS dental costs differ from DCO (Dental Care Organization) costs because of the delivery system. Ms. Myers also felt there was a problem in the data collected by OMAP, as the UCRs (Usual, Customary, and Reasonable charges) were replaced by OMAP's fee schedule and therefore would not be useful as the basis for the benchmark calculations. She suggested using commercial data, which includes the UCR along with a profit.

Generally speaking, Tom Coogan felt that comparing to other states data could be a useful tool, but that it would depend on which areas Mercer has good data for and whether the states are comparable to Oregon.

Mr. Holt considered the question of "what is cost?" Is it the amount the system pays to purchase the service or what the state should effectively be able to pay for acquisition of a product, as in the case of prescription drugs. He sees the ability to manage costs in

the latter case as being greatly reduced. As for the methodology proposed, he suggested working with two categories of drugs instead of three -- brand name + non-competitive generics and competitive generics (MAC list). This more accurately reflects the contracting that takes place. He is concerned that a single blended rate for drugs will not paint a good picture for the legislature since Medicaid is heavily weighted with the higher priced mental health drugs. He also asked what methodologies would be used to establish dispensing costs for drugs. Mr. Eichman indicated that the Secretary of State had put out a report on dispensing fees for institutional drug costs but there is not something similar for non-institutional dispensing costs.

Mr. Gallant saw that the effort at arriving at the cost of the drug was a non-starter because that information, unlike that for other health services, proprietary and federally protected information. Furthermore drugs are not price regulated, as are the other services. Ms. Davis thought that this is one area where the information on other states could be useful as they are all employing various methods for controlling their drug costs.

Dr. Joel Daven pointed out that mental health (class 7 & 11) drugs are being carved out from the managed care capitation rates and yet are often presented to the legislature as part of the costs of managed care (even though the drugs are provided on a FFS basis).

Bill Guest advised that Mercer look at all of the components that go into drug costs be analyzed in total (AWP, discounts, rebates, administrative fees), and the manufacturers will often lower one component while raising another in the negotiation process. Also, the administration fees from the PBMs (pharmacy benefit managers) should be included in the prescription drug costs as opposed to the managed care administrative component.

Mr. Earls suggested an alternative approach on establishing the benchmark for prescription drugs. He thought one might focus only on the commercial rates for these services, since the market is establishing the price. This provides the best “apples to apples” comparison for acquisition costs. He does believe the market equilibrium methodology works well in the other service categories.

V. Next Steps

At the next meeting, Mercer will have gained access to at least some of the actual data and will be able to show some preliminary calculations in developing benchmark rates for sample categories of services.

VI. Adjournment

Darren Coffman adjourned the meeting of the HSC Actuarial Advisory Committee at 5:00 pm. The next meeting will be held Wednesday, May 26, 2004, 11:00 am to 1:00 pm, in conference room 103, of the Oregon State Library, 250 Winter Street NE, Salem, OR.

MINUTES
HSC Actuarial Advisory Committee
May 26, 2004

Members Present: Kevin Campbell, Tom Coogan, Joel Daven, MD; Kevin Earls; Scott Gallant; Tom Holt, CAE; Rick Jones; Rich Monnie; Sarah Reeder; William Murray, MD (via conference call).

Members Absent: Barney Speight

Staff Present: Darren Coffman; Alison Little, MD, MPH; Bruce Goldberg, MD; Laura Lanssens.

Also Attending: MaryLou Hazelwood, RN, Office of Medical Assistance Programs (OMAP); Marc Berg, Providence Health System; Diane Lund, Oregon Health Forum; Jane Meyers, Oregon Dental Association (ODA); Ann Uhler, Mental Health Care & Chemical Dependency Subcommittee; Carmelina Rivera, RPh, Kevin Geurtsen, ASA, Eric Michael, Pharm.D, BCNP, Ed Fischer; and Stephanie Davis, Mercer Government Human Services Consulting; Bill Guest, Cascade Comprehensive Care, Inc (via conference call).

I. Call to Order

The HSC Actuarial Advisory Committee was called to order at 11:03 am in Conference Room 103 of the Oregon State Library, 250 Capitol Street NE, Salem, OR. Introductions were made all around.

II. Goal of Meeting

Dr. Bruce Goldberg explained the general issues around the process to date, including the concept of market equilibrium, although that equilibrium may be dysfunctional. The goal is for today's discussions to guide and inform the Health Services Commission, which meets May 27.

III. Timelines

Darren Coffman gave a brief explanation of timelines. The legislative bill calls for the final report on benchmarking to be available August 1 of this year. The next set of meetings will occur in July after a draft report is completed by Mercer. A potential meeting date of July 21 was suggested, but several conflicts were noted; therefore, it was decided to finalize a date via email. Mercer has preliminary numbers for physician services that will be discussed today, but final numbers will not be available until later. He requested permission to contact members of the committee individually, as the

numbers become available, for their feedback, prior to the next meeting. The committee agreed.

IV. OHP Actuary Benchmarking Services

Stephanie Davis began the presentation by introducing the Mercer team members and referring to the handout. She noted the importance of presenting data in context, thus allowing important information to be communicated to decision-makers, even though it may not be used in the actuarial process. She quickly reviewed material covered from the last meeting, including the importance of equity among provider groups, and that average re-imbursement is being used as a proxy for costs.

Kevin Geurtsen, Mercer actuary, reviewed the methodology. He noted that the benchmarking period is July 2005 to June 2007. The concept of market equilibrium is the only way available, given the resources, of approximating cost. This concept states that there are different payment sources and a certain mix of services, and if one payment is unacceptable, another source can be inflated to make up the difference. In general, because there is no mass exodus from the medical marketplace, and likewise no massive influx, the system must be in some sort of balance. This may be because alternate sources of income are being identified.

Things are a little different in the area of pharmacy. Therefore, Mercer is suggesting the use of a separate methodology they are calling Benchmarking Against Better Purchasing Approaches. Kevin Earls asked for additional discussion of the issues surrounding pharmacy. Kevin Geurtsen responded that market equilibrium assumes that there is a natural pressure applied from suppliers and consumers (traditional economics). However, in the field of pharmacy, there is not much pressure coming from the payers, since they have no control over the supply or the demand. He likened the situation to gasoline; since there is no pressure, the market really isn't in equilibrium. Therefore, Mercer intends to recommend strategies to help control costs, but will not make proposals that are unfeasible in the current market. Bruce Goldberg re-iterated the importance of pharmacy, noting the concurrence of committee members that costs are not controllable in this sector, while they are in all the others, and that it is an issue that the State needs to address.

Mr. Geurtsen discussed the different payer sources; Medicaid/Medicare, commercial and the uninsured. One of the assumptions made by Mercer is that the uninsured do not have a huge impact on the medical marketplace.

Mercer is using the most consistent data sets and sources that they can find. He referred to the Society of Actuaries April 2004 newsletter that supports the concept of the market equilibrium. However, prescription drugs are not in equilibrium, since there is no downward pressure to control costs. Here they will use a different approach, one that identifies reasonable strategies for bringing costs down.

Kevin Earls commented that the piece that is missing is the cost of production. For example, for hospitals, 2 payer sources (Medicaid and Medicare) are paying below the cost of production, with the shortfall being made up by the commercial payer. For prescription drugs, on the other hand, all three payer sources are paying above the cost of production. Since the three payer sources are quite similar for drugs, it suggests that an equilibrium exists, but the context of profit margin is missing. For hospitals, the profit margin is 4-5%, while for pharmaceutical companies, it is substantially higher.

Kevin Geurtsen from Mercer discussed the difficulties of measuring the costs of production in the medical marketplace. In the current exercise, it is more important to measure the cost to the payer, as that is the reality of the marketplace, rather than the costs of production. He stated that they do try to identify what the profit margin is, but are not always successful.

He next presented some descriptive statistics. 63 percent of the population has some kind of commercial insurance, 12% have Medicaid, 11% have Medicare and 14% are uninsured. Total health care dollars spent per category of service is also displayed in the handout. He noted that there is not much difference between Oregon and Washington, but there is some difference nationally. He referred to the handout showing profits for the fully capitated health plans, dental plans, and a variety of other entities, though it is difficult to get "apples to apples" comparisons. He noted that Fortune 500 companies nationally had an average profit margin of 4.6% in 2003, while commercial banks had an average margin of 18.6%.

Joel Daven asked if there were graphs for mental health. The reply was that Mercer is working on trying to get consistent data, but doesn't have it yet.

In response to a question, Eric Michael admitted that pharmaceutical companies are relatively insulated from the pressures of the marketplace. The example of Norvir was given, where Abbott increased the price of the drug 500%. He noted that the Department of Justice in looking into extreme cases like that. Mr. Gallant felt it was more accurate to say they were completely insulated, and Mr. Michaels responded that rebates result in partial pressure. Mr. Gallant responded that the key difference is an ability to set price, which no other health care entity can do.

Marc Berg asked whether the strategy was to create a greater imbalance in payments, such as exists in other sectors where commercial subsidizes the governmental payers, in order to get the profit margins lower. Kevin Geurtsen responded that one of the goals of the current exercise is to identify what can reasonably be achieved, without making the situation worse. It is anticipated that if costs are lowered for one payer, the industry will make that up in another. Dr. Goldberg clarified that the group is not setting policy regarding what the state will pay, nor promoting cost shift in the pharmaceutical market. Rather, the goal is to highlight the issue and promote equity between sectors using the tools available to us, realizing that the tools are insufficient to completely correct the problem.

Kevin Earls asked if risk withhold dollars are reflected in the fully capitated health plan profit margin. Stephanie Davis said they used the financial statements, but did not delve deeply into them to be able to answer that question, and that unless it was obvious, they probably didn't capture it. If there is a particular organization that he is wondering about, she can research it more. It was noted that returned risk withhold is considered physician income, hence does not show up in the profit margin. Bill Murray stated that risk withhold return should not be considered additional money or a true surplus. It is simply a mechanism to manage the budget. He cautioned against pulling this number out without understanding it. Bill Guest agreed, noting that the interim rates that are set reflect the amount of risk that each party is willing to accept.

Stephanie Davis said she did not feel this was a significant issue, and that the handout gives a general picture of how the industry is doing.

Kevin Campbell had a concern regarding the lack of parity for mental health and addiction services, which represents a huge cost shift.

Kevin Geurtsen spoke about data sources, noting that Medicaid data will be one of the best sources, as they will have both fee-for-service and encounter data from the state. For pharmacy, they will reference the Mercer MAC list. For Medicare, they will be using Oregon-specific data for broad service categories. Detailed data from CMS would take 18 months to obtain. Commercial data is available from selected insurers in the state. They will also use the MARS database (which captures just about everything possible for Medicaid), CMS data from other states, other healthcare organization financial statements and other provider financial statements. Mercer currently has Medicaid data for 13 states.

Kevin Geurtsen briefly referred to some of the acronyms for prescription drugs, and a pie chart in the handout that showed the percentage cost for each different category of cost for drugs on a national basis. The largest cost is ingredient cost. Other components include rebates, copays, and dispensing and other fees. Kevin Geurtsen noted that the pie chart is in equilibrium by itself, but that changes in one part of the chart will impact costs in the others. The primary data source for pharmacy will be the Mercer MAC list. Eric Michael explained that the Mercer MAC list is based on Medicaid best practices, ensuring drug availability throughout the state. Stephanie Davis noted that Eric Michael would be discussing long-term strategies that the state needs to consider in the narrative of the report.

Eric Michael began the discussion of prescription drugs by explaining different types of "better practices" which can be used to reduce costs:

- Preferred drug lists (PDLs), or formularies, include certain drugs that are considered the most effective, then additional drugs are added based on cost (both acquisition costs and rebates). A mandatory PDL can result in savings of 3-7%. CMS requires a minimum of 15.1% rebate for brand name drugs and 11% for generics. Most states do not include psychiatric drugs on their PDLs. Some who have, such as Maine, have found it disastrous, and reversed their

policy. Oregon has a PDL but it is not mandatory. Stephanie Davis suggested that Oregon might want to make it mandatory.

- 340b programs involve special pricing that is set up for rural health centers, Indian reservations and inter-city hospitals, in which brand name drugs are discounted 51% off of average wholesale price (AWP). Some states are encouraging the use of these centers for injectables.
- A combined dataset is where the medical and drug databases are merged, allowing disease management. Missouri is the only state that is doing this right now, although some commercial insurers have embraced it. This also helps with point of sale edits, such as step therapy.
- Dose optimization is finding the most cost-effective dosing schedule. Some states are mandating this. If patients are taking medications less often, they are more compliant, and the program can result in 0.5 to 1% decrease in total drug spend.
- Step therapy is another option, which helps to balance consumer advertising. Missouri and Idaho have embraced this, as have other states. It can result in a 0.5 to 1% decrease in costs.
- Quantity limits are often based on the manufacturers recommendations, and can result in a 0.5% decrease in drug spend. This is usually a hard edit, hence a lot of the burden is on the pharmacists. It is important to have a well thought out implementation plan.
- Reimbursement based on acquisition cost data was discussed next. CMS requires that the actual cost of the prescription and a reasonable dispensing fee is all that is reimbursed. However, Texas is the only state that reimburses pharmacies what it really costs to dispense a prescription. Usually, pharmacists make a margin on the drugs they dispense. However, Texas requires the manufacturer to tell the state what they charge the wholesalers that supply the pharmacies. They in turn reimburse those pharmacies their actual cost, plus a dispensing fee. Maine intends to add a similar program. One disadvantage is that it is a labor-intensive program; Texas has 6 FTEs to implement it. Tom Holt suggested including a brief statement on each slide noting which piece of legislation would need to be changed to allow the program to be implemented. Bill Guest commented that pharmaceutical purchasing is a bit of a shell game, in that the AWP, which contracts are based on, varies significantly. He gave the example of albuterol, which has an AWP of $14, but the actual price that a PBM may be reimbursing the pharmacy may be as low as $4. Eric Michael concurred, explaining the concept of transparency; the cost of filling a prescription in rural Oregon is much higher than it is in downtown Portland, hence the PBM will reimburse differently. The greatest spread is on generics.
- Multi-state purchasing is the pooling of purchasing between states to achieve economies of scale. The limitations of this are small numbers, since most states have the bulk of their population carved out into managed care. Savings can approach 1-2%.

Kevin Geurtsen next discussed physician services, and the equilibrium concept (all payers for all services taken together define the equilibrium). He qualified the data

presented, noting that it was preliminary, that co-pays are not yet included, nor is balance billing for Medicare. The preliminary benchmark is around $47. This is the type of information that is going to be provided for all the specialties.

Scott Gallant expressed concern over the Medicare data, given that reimbursement in Oregon is significantly lower than it is in other states, resulting in an artificially low baseline. He is concerned about rising practice costs, and quoted the AMA as saying that practice costs have increased from 1991 to 2003 by 41% while Medicare payments increased 18% in that period. Ed Fisher asked if his main concern was the inflation factor Medicare was using, or the geographic adjustment for Oregon. He responded that he was willing to discuss potential solutions.

Kevin Geurtsen agreed that the reimbursement schedule for Oregon shows a discrepancy, and in general, Medicare is not going to pay the cost of doing the service. However, what is lacking in one payer source will be made up by another -- the equilibrium concept. He gave an example of the commercial market place. Because of limits placed on the two governmental payer sources, the third payor, commercial, is allowed to balloon out of control. He agreed that the governmental payer sources are not paying cost, but they are not being used as the benchmark. He gave the example of dental veneer, which is not paid for by insurance, but is being offered and people are paying for. This is a way to maintain the equilibrium in the dental marketplace. In any marketplace one will find a way to bring in the money and, if not, then the business will leave the marketplace.

Scott Gallant responded to the analogies presented, expressing concern that they were not "apples to apples" comparisons. He stated that the physician marketplace is not at equilibrium, because hospitals and physicians are adjusting to the degree that they can by no longer taking Medicaid or Medicare patients. Bruce Goldberg agreed, saying this is a sub-par standard. Scott Gallant replied that Mercer is using a depressed rate for both Medicaid and Medicare reimbursement. This is and should not be a real benchmark because it is flawed.

Kevin Geurtsen responded that because of the depressed rate of payment from governmental payers, physicians are negotiating with commercial insurers for a higher rate that provides the income level required to stay in business. Practice cost is factored into what the cost is.

Dr. Goldberg explained this is not really getting at true cost; instead, we are using average reimbursement as a proxy of cost. He asked the members if they knew of a better way, stating that now is the time to speak up. No suggestions were forthcoming. He stated that the intent was to indicate the caveats and problems with the methodology in the report.

Scott Gallant asked for some recognition of inputs that are readily acknowledged as being low. He was concerned that the report would suggest that it was acceptable to have a significantly decreasing number of participants in the Medicaid and Medicare

programs in Oregon. He was concerned that this report would not sufficiently demonstrate the access problem that exists.

Stephanie Davis commented that Mercer would add more to the report, describing the limitations of the project, but that if the benchmark presented was too low, we would be seeing physicians leaving the state. One data source that they have not examined yet, but plan to, is the number of physicians coming into the state, and leaving the state. She feels it will be helpful to discuss this in detail with Mr. Gallant at a later time. She again discussed to concept of the equilibrium, saying that, given all the payer sources, physicians are getting by. Scott Gallant expressed dismay that the benchmark is "getting by".

Kevin Geurtsen discussed again the concept of the equilibrium, and that it exists in all marketplaces, and that if pay is insufficient, and a better offer is available, a personal choice may be to move. This is true for physicians as well, and the average reimbursement becomes the proxy for the benchmark. However, we do need to be cognizant of the nature of the industry in order to put the right assumptions in play.

Dr. Daven asked two questions; first, he asked for a definition of unit cost. Secondly, he noted that the denominator was the percent of population, while he thought that payer mix might be more appropriate.

Kevin Geurtsen explained that the "unit" is defined as a visit. The denominator calculation actually includes the percent of payer mix. Stephanie Davis stated that the units should be "reimbursement per visit".

Scott Gallant noted that the payer mix would look very different between Eastern Oregon and other parts of the state. Kevin Geurtsen responded that it was decided at a prior meeting not to look at geographic differences within the state. Stephanie Davis stated that the report should note that geography is different, and additional monies should not be allocated across the board.

Tom Holt commented on the equilibrium, noting that in the health care system, equilibrium is principally a cost shift to the private sector, but not all sectors have the ability to make that shift or to control their patient mix. He requested that such an explanation be included in the report.

Kevin Geurtsen acknowledged that the equilibrium relies on pressure, noting that the cost shift to the commercial carriers is being cost-shifted further onto employees. He stated that if health care were truly a free market, this pressure would succeed in bringing costs down.

Dr. Goldberg stated that the intent of this exercise is not to change this, but to highlight the situation, and to set capitation rates. At some point, one has to pick a value for services to put into the calculation. Currently, Medicare is the value used to base the rates on. The goal now is to highlight what the discrepancies are and expose the inequities in the market. He agreed that we need to call this a dysfunctional equilibrium.

Dr. Goldberg further discussed the definition of units. He noted that most physicians use RVUs to measure reimbursement. He suggested that another column be added showing cost/ RVU, in addition to cost/visit.

Kevin Geurtsen noted that the purest measurement is per member per month, and that to use other units, assumptions need to be made. Ed Fischer noted that it is complicated by the fact that non-physician services are included in the physician bucket.

Kevin Campbell questioned the wisdom of using Medicare as the measuring stick, and asked if there were other options. He suggested possibly using “all payers” as the measuring stick.

Kevin Geurtsen agreed, stating that “all payers” is calculated first, and then the Medicare benchmark if derived from that. It would be easy to leave the benchmark there if that is what the committee chose.

Ann Uhler stated that the mission of mental health and chemical dependency has always been to serve the poor and Medicaid, not commercial, which means different assumptions need to be applied. Kevin Geurtsen acknowledged that it was difficult to recognize differences in mission in the data. Stephanie Davis added that they would be looking at supplemental studies, as well as additional data, to reach a more accurate result.

Concern was expressed over the short amount of time left to accomplish a lot of work, and thought that mental health would be more complex and difficult than physicians. Stephanie Davis stated that they would be in touch with individuals on the committee before the next meeting. Kevin Campbell asked whether the supplemental government funding listed in the handouts as supplemental data included institutional funding, such as direct contracts for residential beds and state hospitals. He noted that commercial insurance really does not play a role.

VI. Adjournment

Bruce Goldberg had to leave the meeting at 1:00 pm due to another meeting elsewhere. Darren Coffman reminded members that they would be contacted about a one-on-one meeting in the near future. The meeting of the HSC Actuarial Advisory Committee was adjourned at 1:10 pm. The Committee is looking at meeting mid July 2004. Staff will contact the members regarding date, time and venue of the next meeting.